



Belgium's policy on global health: institutions, priorities and challenges

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Introduction

During the past two decades, health has increasingly gained importance in global policy and diplomacy. Beyond the humanitarian and development aspects, several states became aware of their own security and economic interests related to health issues elsewhere in the world (Fidler, 2009; Kickbusch, 2011). Consequently, there has been an unprecedented growth in funding for health, several new partnerships and initiatives were launched and health emerged on the agenda of high-level fora such as the UN and the G7/G8. In addition, more attention has been given to global health by national governments. Several of them have launched national global health strategies.

In this article, we will discuss the global health policy of Belgium. Belgium has a long tradition in international support to health, dating back to the colonial times. In need of healthy people to boost the economy, a referral district health system was developed in the Democratic Republic in Congo (DRC). This has later become an example for other countries (Simoens, 2012). Rooted in this colonial history, the Institute of Tropical Medicine (ITM) in Antwerp is still a world-leading institute for research and training on medicine and healthcare in developing countries. There is also a lot of expertise within other

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academic institutions, NGOs, and the public administration in Belgium. Lastly, some Belgian citizens have occupied key positions within international health institutions, e.g. Peter Piot², Marleen Temmerman³ and Lieve Franssen⁴, adding to the extensive expertise of Belgium in global health. Taking this history and expertise into account, it is not surprising that health is a priority area of the Belgian development cooperation. According to the OECD-DAC (2015), 15% of Belgium's sector allocable aid was targeted towards health during the past years. With this figure Belgium belongs to the top European donors for the health sector⁵ (in relative terms).

Despite the large history and expertise on this theme, academic literature on Belgium's current global engagement in the health sector is non-existent. This article aims to fill this gap, by discussing Belgium's policy in global health over the past ten years. The findings are mainly based on document analysis and 11 expert interviews⁶. The next part discusses the main conceptual debates on global health policy. Then, these concepts are applied to the Belgian context, by analysing the institutional set-up, the Belgian vision and its priority areas. While the main focus is on Belgium, its policy is contextualized by referring to other countries as well. Lastly, the conclusion will summarize the main findings and discuss some future challenges.

Conceptual debates on global health policy

The growing importance of health in global policy and diplomacy gave rise to the concept of global health. However, this concept is understood differently among academic scholars and policy makers⁷. An often cited distinction is the one between 'international health' and 'global health' (e.g. Koplan et al., 2009; Brown, Cueto & Fee, 2006). The term 'international health' originated in the

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⁵ Only the UK, Luxembourg and Ireland provide relatively more aid to the health sector

⁶ People from the following services and organizations were interviewed: Directorate-General for Development Cooperation and Humanitarian Aid (2), Federal Public Service (FPS) of Health, Food chain safety and Environment – external relations unit, the Belgian Technical Cooperation, the Cabinet of the Federal Minister for Development Cooperation, the Cabinet of the Federal Minister for Health, Departement Internationaal Vlaanderen, Sensoa Belgium, The International Center for Reproductive Health, Médecins Sans Frontières Belgium and Memisa.

⁷ We will not stick to a strict definition of global health in this article, as the question on how Belgium interprets global health is an integral part of the research. Due to the subtle difference between international and global health, these terms will also be used interchangeably.

colonial period and is associated mainly with assisting developing countries in fighting infectious and tropical diseases. In contrast, the term 'global health' is understood more broadly, focusing on health issues that transcend national boundaries, the health impacts of deepened globalization for all countries, and the need for global action and solutions by a wide range of actors. Nevertheless, the distinction between both terms is quite subtle. Labonté (2014, p.48) rightly states that "much of what has recently been re-branded 'global' is simply old 'international' wine in new bottles". Apart from this semantic discussion there are three more important distinctions to make regarding global health policies.

First, there are several global health perspectives. Kickbusch (2011) states that health became an important foreign policy issue because of three global agendas, namely *security*, *economics* and *social justice*. The *security* perspective is "driven by the fear of global pandemics or the intentional spread of pathogens and an increase in humanitarian conflicts, natural disasters and emergencies" (Kickbusch, 2011, p. 1). Consequently, global health funding is used to contain infectious diseases in other parts of the world or to contribute to stability. The *economic perspective* considers health as a means of maximizing economic development (Stuckler & McKee, 2008). It is not only concerned with the economic impact of poor health on the population of countries receiving international health assistance, but also with the result of a growing global market in health goods and services (Kickbusch, 2011). Lastly, the *social justice* perspective aims to "reinforce health as a social value and human right, supporting the UN MDGs, advocating for access to medicines and primary healthcare, and calling for high income countries to invest in a broad range of global health initiatives" (Kickbusch, 2011, p.1).

Second, and linked to the previous, is the varying institutional set-up of governments. In the past, external health policy was mainly addressed by development ministries, as a remnant of colonial relations. However, as Western states increasingly became aware of their own interests in global health, the subject lifted onto the agenda of ministries of health and foreign affairs. Hence, in a growing number of countries, a 'whole-of-a-government approach' is currently used to address a broad range of global health themes, which has resulted in the development of national global health strategies, such as in Switzerland in 2006, the UK in 2008, Japan in 2011, Norway in 2012 and Germany in 2013 (Kanth, Gleicher & Guo, 2013). The European Commission also defined its role in Global Health in a Communication in 2010.

A third important distinction is the one between vertical (disease-specific) and horizontal (overall strengthening of health systems) health programs and funding. In 1978, the World Health Organization (WHO)'s Alma Ata Declaration on Primary Health articulated the need to focus on basic healthcare systems to reach 'health for all' by 2000 (WHO, 1978). A horizontal, comprehensive approach to health programs had to tackle the shortcomings of the vertical programs which were only targeted at specific diseases. However, the Alma Ata Declaration was quickly forgotten when the world was hit by the HIV/AIDS epidemic, and the pendulum swung back to vertical programs. The global health initiatives that were launched after 2000⁸ are all vertical in orientation. The MDGs also focused on specific health problems, namely child health, maternal health and infectious diseases including HIV/AIDS, TB and malaria. Several international donors prefer this vertical focus as it leads to quick short-term results, which are easier to legitimize towards their population. Furthermore, the security and economic perspectives related to health (cf. *supra*) also tend to focus more on specific diseases (Stuckler & McKee, 2008).

Institutional set-up

In Belgium, global health competences are not only shared by several policy sectors (mainly development cooperation and health), but also by the federal government and the federated entities. Despite some information-sharing and coordination between the governmental services, a whole-of-a-government approach is lacking. In the following paragraphs, we will shortly describe the main actors involved, as well as the level of coordination between them.

On the federal level, the main actors are the Ministry for Development Cooperation, the Ministry for Health, and their administrations. Under the competence of the Ministry of Development Cooperation, the health unit of the Directorate-General for Development Cooperation and Humanitarian Aid (DGD) is responsible for drafting health policies and following up on the governmental development cooperation plans in the health sector⁹. The Belgian Technical Cooperation agency (BTC) is responsible for the implementation of the direct bilateral aid in the health sector. Under the competence of the Minis-

⁸ E.g. the Global Fund against HIV/AIDS, Tuberculosis and Malaria, the Global Vaccines Initiative (GAVI) and the US President's Emergency Plan for AIDS Relief (PEPFAR).

⁹ Health is currently a focal sector in 8 of the 14 federal partner countries, namely Benin, DRC, Rwanda, Burundi, Niger, Senegal, Uganda and Guinea.

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try of Health, the 'external relations unit' of the Federal Public Service of Health, Food chain safety and Environment (FPS Health) is mainly dealing with those international health issues that are of importance for public health in Belgium, such as international mobility of patients and health workers, safety of medicines, and antimicrobial resistance. Occasionally, the federal Ministry of Foreign Affairs and its administration are also responsible for some highly politicized themes, such as the status of Taiwan at the WHO, or health in the occupied Palestine territories.

As healthcare and development cooperation are partly federated, Belgium's federated entities also have some competences regarding global health. Flanders International and Wallonia-Brussels International are responsible for development cooperation in the health sector¹⁰. In addition, specific departments within the Flemish Agency for Care and Health and the DG Health of Wallonia public service are dealing with the relations with the WHO for those themes that relate to their competencies. Lastly, the Representations of Belgium, Flanders and Wallonia-Brussels towards the international organizations in Geneva and towards the EU are also dealing with global health issues.

The formulation of the Belgian position for the WHO and other multilateral health-related bodies takes place through the permanent inter-ministerial coordination mechanism COORMULTI, located within the Ministry of Foreign Affairs. Although the Ministry of Health has the final responsibility in representing Belgium at the WHO, the COORMULTI is used to consult and inform the other relevant government services. In general, the COORMULTI is evaluated as an efficient platform to inform each other on certain dossiers, divide responsibilities and reach consensus on a Belgian position (interviews 1, 2, 5, 6 and 10). Besides the COORMULTI, collaboration amongst governmental services takes place on other specific themes that do not directly relate to multilateral fora. For example, DGD consults the other government services when it develops a new health sector strategy. Another example resulting from coordination is the decision of the federal government to pull out of the health sector in Mozambique in 2013, since Flanders has a comprehensive program in that country (interview 1). Within Wallonia, a platform has been set-up recently to bring together all actors (personal e-mail).

¹⁰ The Flemish government funds the health sector in Mozambique and Wallonia-Brussels considers health a priority sector in Benin, Bolivia, Palestine and Vietnam.

Besides the governmental services, another important institution is the platform *Be-cause health*. This platform brings together about 50 organizations and 200 individuals who are working on international health and development cooperation, mainly NGOs, academic institutions and government services (the latter as observing members). Through the platform, information is shared and specific topics are discussed within 9 working-groups. The platform is also consulted in policy-making, for example in case of the development of health sector strategies.

Despite the COORMULTI platform and other occasional coordination efforts, several interviewees admitted that they were not fully aware of the policies and organization of other government services (interviews 1, 2, 5 and 6). This confirms the suggestion of the OECD-DAC (2010) that “Belgium’s ministries would benefit from formulating common policy approaches that do not undermine their aid policies beyond the official position for multilateral consultations”. This is certainly the case for global health.

‘Healthcare for all’: a focus on social justice

As became clear in the previous part, in contrast to several other donors, Belgium does not have a global health strategy developed by all actors working in this area. DGD published several policy documents on the health sector, but these cannot be considered as global health strategies, as they only focus on the federal development cooperation. In absence of an explicit global health strategy, we will focus the analysis of the Belgian vision on the federal development cooperation, as we consider this the most important Belgian actor in this field, both in terms of money spent and international influence.

As discussed before, there are three main global health perspectives, namely security, economy and social justice. Although health has increasingly become part of the security and economic agenda of international players, these perspectives are less prevalent in Belgium. What characterizes the Belgian position in global health is its strong adherence to social justice – although this might change in the coming years.

In 2001, the Belgian government – as president of the EU Council – and the ITM organized an international conference called “Healthcare for all”, during which a declaration was endorsed by all participants. It called on the international society to recognize healthcare for all as a human right, to acknowledge the multi-sectoral approach towards health, and to reorient the

focus of specific disease control programs towards health systems strengthening (ITM, 2001). These principles still constitute the basis of the Belgian engagement in global health. The starting point of the main policy note 'The right to health and healthcare' (DGD, 2008) is that "access to quality healthcare is an inalienable right and an essential element in the fight against poverty and inequality". Also the specific policy-notes on AIDS (DGD, 2006), reproductive healthcare (DGD, 2008) and universal health coverage (DGD, 2012) focus on the right to health and healthcare. Furthermore, the focus on supporting 'health for all' is linked with the national social protection model. As mentioned in the document on Universal Health coverage (DGD, 2012), the Belgian expertise in and experience with mutual healthcare insurance can help to promote and support national healthcare coverage in partner countries. Aiming to realize the universal right to access to healthcare, one of the core focus areas of the Belgian cooperation in health is health system strengthening (HSS) as will be discussed in the next part.

Although the 'healthcare for all' vision is linked mostly to the social justice agenda, the security and economic aspects are not totally non-existent in the Belgian policy. However, these aspects are less important in comparison with other countries.

Despite the huge pharmaceutical sector in Belgium, most interviewees agreed that economic interests do not play a substantive role in the Belgian global health policy. This is essentially because the main responsibilities for global health are shared by the FPS health and DGD, who are quite wary about the influence of economic interests (interview 5 and 6). This contrasts with other countries, like the Netherlands or the UK, where national economic interests are explicitly mentioned in policy documents on global health and international development (e.g. Dutch Ministry of foreign affairs, 2013 & UK government, 2011). Nevertheless, pushed by other Ministries, economic interests might play an occasional role in Belgium too. For example, at the regional committee of the WHO in September 2014, the medical displays of the Belgian company BARCO were promoted during a social event organized by the Ministry of Foreign Affairs (interview 5). Another example relates to the vaccines of Unicef, which are mainly bought from Belgian pharmaceutical companies. The government is currently analysing how it can facilitate this relationship (interview 6). Linked to the economic perspective is the debate on the protection of Intellectual Property and access to medicines, on which the Belgian position is dubious. The policy note of DGD (2008) claims that

Belgium should support “the countries that wish to make use of the flexibility measures set out in the TRIPS agreement”. However, one interviewee claimed that Belgium generally does not oppose the position of the EU on this matter, who is often accused for stressing economic interests above health concerns (interview 7).

Several interviewees mentioned that Belgium is far less focused on security issues than some other countries (interviews 1, 2, 3, 4 and 5). An example of this is the Belgian reaction on the Ebola epidemic. Although part of the Belgian measures in reaction to the outbreak also aimed to protect national interests (interview 10), Belgium was far less stressing security issues than some other countries, such as the UK and the broader Anglo-Saxon world (interviews 2, 3 and 5). The main focus of the Anglo-Saxon world was to set-up measures to prevent infectious diseases from spreading easily in the future. This resulted in a vertical approach, focusing only on containing Ebola and setting-up a contingency fund for infectious diseases. However, Belgium and most other European countries, considered the Ebola outbreak mainly as the consequence of failing health systems. Therefore they preferred a more comprehensive, horizontal approach. In his speech on a high-level conference on Ebola, Minister for Development Cooperation Alexander De Croo (2015) stated that “systemic crises require systemic responses. National health systems need to be inclusive so that affected people can rely on their governments for healthcare and protection”.

Priority areas

The federal law for development cooperation lists healthcare as one of the priorities of bilateral cooperation. More specifically, it mentions “healthcare, including the access to health for all, reproductive health and the fight against the major endemics, including a transversal approach to HIV/AIDS healthcare” (Belgian Ministry of Foreign Affairs, Foreign Trade and Development Cooperation, 2013, art. 19). This quote covers the main priorities of the Belgian development cooperation in the health sector namely HSS, HIV/AIDS, and sexual and reproductive health and rights. DGD has developed specific policy notes elaborating on these principles. In 2015, it started consultations for a new health sector policy note, which will integrate all the former documents and address some actual themes. The specific content of this new note is not known yet, but most actors involved in the process said that the

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dominant principles will probably remain unchanged (interviews 1, 2, 3, 9 and 11). In the next paragraphs, we will discuss these priorities more in depth, as well as the potential tensions between them.

First, referring to the Alma Ata Declaration and criticizing the purely vertical approaches, Belgium clearly supports the idea of Health System Strengthening. The policy note 'A right to health' of DGD argues that "the development of an efficient and sustainable health system able of providing reliable healthcare for all is the best means to achieve [the universal right to health]" (DGD, 2008, p.5). Belgium wants to assist partner countries in building a qualitative health system by educating health workers, integrating the fight against certain diseases within the health system and strengthening the control and distribution of medicines. Importantly, the principles of aid effectiveness are stressed as well, claiming that Belgian interventions should be aligned with the priorities and systems of the partner countries. This system-approach is largely shared among other European donors. The EU Communication on the EU role in global health stresses a comprehensive approach focusing on all components of the health system (European Commission, 2010). Through the Member States Experts group on global health, Belgium has contributed actively to the development and content of this EU document (interview 1).

The horizontal focus is also reflected in Belgium's contributions to the WHO. In 2008, Belgium decided to direct all DGD's voluntary contributions to multilateral agencies' core budgets starting from 2009, instead of earmarking it for specific projects or priorities. This decision has been lauded by the OECD-DAC (2010) and is especially relevant for the WHO, whose budget is largely financed through voluntary contributions (80%). Belgium is one of the few countries that does not earmark its contributions to the WHO, as the federal government provides full core flexible funding. However, the voluntary contribution of Flanders towards the WHO is earmarked for a specific program on human reproduction (*infra*).

The focus on HSS is largely influenced by the work of the ITM in the DRC. Some interviewees even referred to the existence of 'a Belgian school' in international public health, which aims to strengthen health systems by focusing on primary healthcare and using the health district as an organizational model (interview 3, 7 and 9).

However, despite this clear horizontal focus, some qualifications should be made. Firstly, a large share of Belgian ODA is also transferred to vertical

global health initiatives such as the Global Fund against HIV/AIDS, TB and malaria. Secondly, there seems to be a growing discussion within the Belgian development cooperation on the efficiency of health system strengthening. Instead of indirectly supporting the system and wait for long-term results, some actors consider a direct approach as faster and more efficient (interview 4). Especially in fragile states HSS is difficult to implement, as the government often does not consider public health a priority and corruption is wide-spread (interview 7). As the health-system in such countries is largely non-existent, more innovative approaches might be needed to address the health needs of the people.

HIV/AIDS is a second priority of the Belgian development cooperation. In line with the increased international attention for HIV/AIDS, the Belgian federal government paid a lot of attention towards HIV/AIDS during the first years of the new millennium. A special coordinator for the fight against AIDS was appointed, several national indicative programs mentioned AIDS as transversal theme and a federal policy note on aids was agreed in 2006. However, as expressed by former senator Marleen Temmerman (2012), the attention towards HIV/AIDS has largely decreased in the past years. As stated by Vandevoorde (2010), the period of 'AIDS exceptionalism' is largely over, as the fight to AIDS is currently entirely linked to the discourse on HSS. This trend has also been confirmed by an analysis conducted by Sensoa (2014), which assessed the federal ODA spending on HIV/AIDS since 2010. It concluded that the amount of projects focusing primarily on HIV/AIDS has decreased drastically in the past years, while the amount of projects that pay significant though secondary attention towards HIV/AIDS has slightly increased.

The third priority is sexual and reproductive health and rights (SRHR), which is a highly contested topic on the international agenda. Having displayed a very progressive stance within national policies on SRHR, Belgium considers this theme also a priority for its external health policies. In 2008, a special policy note on this topic was launched. The note identified three specific areas of cooperation for the Belgian engagement, namely (1) integration of sexual and reproductive healthcare, (2) the fight against sexual violence and harmful practices and (3) sexual and reproductive healthcare and rights during humanitarian crises, conflicts and peace-building.

Minister De Croo is also strongly engaged on the matter. During the 48th session of the UN Committee on Population and Development, he supported a

bigger role for SRHR within the international development agenda (De Croo, 2015). The Flemish government is focusing even more on sexual and reproductive health as it is an important funder of the WHO “Special Program of Research, Development and Research Training in Human Reproduction”, and has been elected in 2015 to chair its Policy Coordinating Committee (interview 2).

Some progressive European countries are grouped in an informal network called the ‘like-minded-donors’, who intend to keep the protection of SRHR on the international agenda. Belgium is also part of this group, but nevertheless uses a different approach compared to the Scandinavian countries and the Netherlands. While the Scandinavian countries are taking a radical stance in the global debate on SRHR, Belgium prefers to build bridges and aims to make gradual progress on certain areas (interview 3 and 6). Furthermore, the Belgian focus on SRHR is also encapsulated in the HSS approach. While the idea of integrating SRHR in the general health system is generally supported, civil society organizations claim that SRHR often requires an additional focus, since the general health system does not cover all SRHR needs (interview 3 and 8). This was confirmed by an evaluation study, which pointed out that the Belgian contribution towards improving SRHR differs a lot, depending on the types of program supported (Depoortere & Dubourg, 2013). While specific SRHR projects cover the specific SRHR needs, the topic gets less attention in primary healthcare projects and almost no attention in the context of health sector budget support. Consequently, the study states that “in the absence of a conscious choice to give particular attention to SRHR issues, Belgium does not really gain visibility in this area”. The evaluation also revealed that the SRHR strategic note was insufficiently known and used by the Belgian actors in development cooperation.

Conclusion

Within this paper we have discussed the Belgian policy on global health. Based on our findings, we can make three main conclusions.

Firstly, a truly ‘whole-of-a-government’ approach towards global health is missing in Belgium. Despite coordination in certain areas, the Belgian engagement in global health is largely defined by the federal department of development cooperation. Arguably, the development of an explicit Belgian global health policy could make all actors more aware of each other’s policies and

responsibilities and would contribute to the coherence and visibility of Belgian's engagement in global health. Secondly, the Belgian perspective is closely linked to the social justice agenda, as it takes the universal right to health and healthcare as a fundamental starting point and prioritizes health system strengthening, sexual and reproductive health and rights and an integrated approach towards HIV/AIDS. Security and economic interests are generally not considered having a distinct impact on the Belgian policy in this field. Thirdly, Belgium pays a lot of attention to multilateral agreements on global health and development cooperation, and its policy on global health is embedded within the EU and WHO policies.

However, the question remains to what extent the Belgian engagement in global health will remain the same in the following years. Although self-interest is currently less emphasized, this might change in the future, due to international developments. As stressed by one of the interviewees, the post-2015 sustainable development agenda – which replaces the millennium development goals – covers a broad global agenda that goes beyond poverty reduction. Furthermore, the agenda is aimed to be 'universal' for all countries, and not only targeted to developing countries. Consequently, the department of Foreign Affairs will play a bigger role in the post-2015 agenda. As we have pointed to the importance of the institutional set-up for donors' vision on global health, this evolution might result in a bigger focus on Belgium's own interests, which do not always align with the interests of developing countries. Another point that remains questionable is the adherence towards the principles of the aid effectiveness agenda. Similar to other countries, Belgium tends to withdraw more and more from direct support to national governments. This however contradicts with the idea of HSS, which assigns an important role to the national government of partner countries. The new sector policy note that will be launched in the course of 2016 will already provide some insights about the future of the Belgian engagement in global health.

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